



# APPLICATION FOR A TEMPORARY MEDICAL PERMIT (For Postgraduate Training or Teaching)

State Form 17598 (R8 / 5-04)

Approved by State Board of Accounts, 2002

Health Professions Bureau  
402 W. Washington St., Rm. W066  
Indianapolis, IN 46204  
Telephone: (317) 234-2060

\* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it.

OFFICE USE ONLY		
Permit fee	Date fee paid (month, day, year)	Receipt number
Permit number	Permit issuance date (month, day, year)	

Applicant

Attach one (1) passport  
type quality photograph  
of yourself taken within  
the last eight weeks.

APPLICANT INFORMATION	
Name of applicant (last, first, middle)	Social Security number *
Address (number and street or Rural Route number)	
City, state, ZIP code	
Telephone number (daytime)	Date of birth (month, day, year)
Place of birth	

Please indicate what address you want your permit sent to (number and street)	
City, State, ZIP code	
Email address	

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY:		
Name of school	Location	Date of graduation (month, day, year)

APPLICATION AFFIRMATION	
I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.	
Signature of applicant	Date (month, day, year)

PRE-MEDICAL / OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED

MEDICAL / OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA (Include ALL internships, residencies and / or fellowships)			
NAME OF SCHOOL	LOCATION	FROM (month, year)	TO (month, year)

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL	
GENERAL LOCATION	DATE

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following, is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any license, certificate, registration or permit you hold or have held?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied a license, certificate, registration or permit to practice osteopathic medicine or any regulated health occupation in any state (including Indiana) or country?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you now being, or have you ever been treated for a drug abuse or alcohol problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been charged with drug addiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been convicted of, pled guilty or nolo contendere to: A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substance or drug addiction? B. Any offense, misdemeanor or felony in any state? (Except for minor traffic laws resulting in fines.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICATION AFFIRMATION	
I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.	
Signature of applicant	Date signed (month, day, year)

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned, requested by the Bureau or any of its authorized representatives in connection with processing my application for temporary medical permit.

I hereby release the aforementioned persons, firms, officers, corporations, association, organization, and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

**AFFIRMATION**

I hereby swear or affirm that I have read the above statements and agree to same.

Date signed (*month, day, year*)

Signature of applicant

**HOSPITAL / INSTITUTION CERTIFICATION FOR A TEMPORARY MEDICAL PERMIT  
OR A TEMPORARY MEDICAL TEACHING PERMIT  
(to be completed by the hospital / institution Chairman / Department Head)**

This is to certify that \_\_\_\_\_ has been granted  
an appointment to serve at \_\_\_\_\_ in  
the Department of \_\_\_\_\_  
located at (*address*) \_\_\_\_\_  
this appointment is for the month and year beginning \_\_\_\_\_ and ending \_\_\_\_\_

Name of Hospital Chairman/Department Head

Title

Signature

Date of signature (*month, day, year*)

Telephone number

(      )